DIRECT ACCESS SCREENING COLONOSCOPY INSTRUCTIONS

Please complete all forms. Attach any additional documents and fax, mail or deliver to the appropriate office location below:

Catonsville:
700 Geipe Road, Suite 230
Catonsville, MD 21228
Phone: 410-247-7500
Fax: 410-247-4227

Columbia:
10710 Charter Drive, Suite 110
Columbia, MD 21044
Phone: 410-992-9797
Fax: 410-730-0942

Thank you for contacting our office for a Direct Access Screening Colonoscopy. This process will potentially allow you to have your procedure without first being seen by one of our gastroenterologists. Please be aware this program is for individuals without any gastrointestinal symptoms with a medical history that meets the guidelines for the program.

1. **A copy of your insurance card(s), front and back.**

2. **A copy of your referral from your insurance carrier, if required by your insurance policy.**

3. **A copy of your most recent history and physical or office visit notes from your primary care physician (PCP) and/or a copy of the office notes from your referring physician. Your PCP can also fax the information to our office.**

Upon receipt of your documents, a physician will evaluate your medical information to ensure you are a candidate for a Direct Access Screening Colonoscopy. Our staff will contact you within 10-14 days to schedule your procedure, or if you do not qualify, schedule your office visit. If you do not receive a call in 10-14 days, please call our office.

Confirmation of your scheduled procedure (or appointment) as well as instructions for your procedure will be mailed to you. Dietary and bowel preparation instructions will be included.

Thank you for selecting Digestive Disease Associates for your medical care.
If you have any questions concerning your procedure or the process, please contact us!

Patient Name: **Account Number:**

Advance Beneficiary Notice of Non-covered Services

NOTE: Your Insurance may not pay for your Colonoscopy if you are under age 50.

It is your responsibility to contact your insurance company to find out if you are eligible for your Screening Colonoscopy Benefit.

Should you decide to have your Screening Colonoscopy and your insurance company denies your claim, you will be responsible for the charges associated with your procedure.

Signing below means that you have received and understand this notice.

I. Signature:	J. Date:

Witness_____

DIGESTIVE DISEASE ASSOCIATES + GASTRO HEALTH

DIRECT ACCESS SCREENING CHECKLIST

PATIENT NAME _____ DOB _____

REFERRING PHYSICIAN _____ GI PHYSICIAN PREFERENCE _____

Please answer the following questions to assess your eligibility for a Direct Access Screening Colonoscopy.

If you answer yes to any of these questions, you may need an office visit before your procedure is scheduled.

Yes	No	
❑	❑	1. Are you over 65?
❑	❑	2. Do you weigh more than 315 lbs and have a BMI above 45? Height _____ Weight _____ BMI _____
❑	❑	3. Have you had a change in your medical history in the last year? **IF YES, PLEASE PROVIDE DATE (MONTH AND YEAR).** ❑ Heart attack _____ ❑ Irregular heartbeat _____ ❑ Coronary artery stent replacement _____ ❑ Stroke _____ ❑ Seizure _____
❑	❑	4. Have you ever seen a cardiologist (heart doctor)? If yes, what is the doctor's name? _____
❑	❑	5. Do you have any current gastrointestinal symptoms that need to be addressed with the physician prior to the procedure? ***(This includes heartburn, abdominal pain, bleeding, weight loss, diarrhea, constipation or anemia.)***
❑	❑	6. Are you currently on dialysis, have a defibrillator, pacemaker, artificial heart valve, breathing issue requiring home oxygen, or being monitored by a respiratory doctor? (**Please circle all that apply.**)
❑	❑	7. Are you on any blood thinners other than aspirin?
❑	❑	8. Will you have any contraindications (problems) stopping any of your medications 5-7 days prior to your procedure? ***(This includes Aspirin, Ibuprofen, Motrin, Advil, or any other non-steroidal medication.)***
❑	❑	9. Are you a diabetic? If yes, do you have an insulin pump? ❑ Yes ❑ No

DIGESTIVE DISEASE ASSOCIATES + GASTRO HEALTH

PATIENT DEMOGRAPHICS AND INSURANCE FORM

TREATING DOCTOR (PLEASE CHECK) ❑ ABERNATHY ❑ ALEX ❑ ANDORSKY ❑ BANEGURA ❑ CROSSE ❑ JOY ❑ P. KIM ❑ MOUSSAIDE ❑ NARAYEN ❑ RAVENDHRAN ❑ SALAS ❑ SARDANA ❑ SOLOMON ❑ VAN DEN BROEK

TODAY'S DATE	❑ DR. ❑ MRS. ❑ MS. ❑ MISS ❑ MR.	FIRST NAME	MIDDLE	LAST	DATE OF BIRTH	SEX ❑ M ❑ F
STREET ADDRESS		CITY	STATE	ZIP		
WHEN WE CONTACT YOU TO REMIND YOU OF YOUR APPOINTMENT, SHOULD WE CONTACT YOUR? ❑ HOME PHONE ❑ CELL PHONE		HOME PHONE	WORK PHONE			
		CELL PHONE	EMAIL ADDRESS			
MARITAL STATUS ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated		ETHNICITY ❑ HISPANIC OR LATINO ❑ NOT HISPANIC OR LATINO ❑ DECLINED ❑ OTHER_____				
RACE ❑ AMERICAN INDIAN ❑ ASIAN ❑ BLACK OR AFRICAN AMERICAN ❑ WHITE ❑ DECLINED ❑ OTHER_____				PRIMARY LANGUAGE		
EMPLOYER		IN CASE OF EMERGENCY, NOTIFY		DAYTIME PHONE		
PERSON FINANCIALLY RESPONSIBLE ❑ SELF ❑ PARENT ❑ OTHER_____		IF DIFFERENT THAN PATIENT: NAME		PHONE NUMBER		
		ADDRESS				

PRIMARY INSURANCE INFORMATION

COMPANY NAME	PHONE NUMBER	
POLICY NUMBER	GROUP NUMBER	
NAME OF POLICY HOLDER		
EMPLOYER		
POLICY HOLDER'S DATE OF BIRTH	SEX ❑ M ❑ F	RELATIONSHIP TO INSURED

SECONDARY INSURANCE INFORMATION

COMPANY NAME	PHONE NUMBER	
POLICY NUMBER	GROUP NUMBER	
NAME OF POLICY HOLDER		
EMPLOYER		
POLICY HOLDER'S DATE OF BIRTH	SEX ❑ M ❑ F	RELATIONSHIP TO INSURED

REFERRING AND PRIMARY CARE PHYSICIAN INFORMATION

REFERRING PHYSICIAN (RP)	PRIMARY CARE PHYSICIAN (PCP)
PHONE NUMBER	PHONE NUMBER

HOW WERE YOU REFERRED TO OUR PRACTICE?
❑ PRIMARY CARE PHYSICIAN ❑ OTHER PHYSICIAN ❑ OUR WEBSITE ❑ FRIEND ❑ RELATIVE ❑ OTHER_____

PHARMACY INFORMATION

PREFERRED PHARMACY	PHONE NUMBER
ADDRESS	

DIGESTIVE DISEASE ASSOCIATES + GASTRO HEALTH

MEDICAL HISTORY FORM

PATIENT NAME _____ DOB _____

REFERRING PHYSICIAN _____ PRIMARY CARE PHYSICIAN _____

INSTRUCTIONS: This questionnaire will assist us in understanding your medical condition. Please answer all the questions fully and print legibly. If you are uncertain about any questions, please use a question mark (?)

CHECK ONE OR MORE OF THE FOLLOWING REASONS THAT APPLY:

❑ **NONE** Are you constipated? ❑ Yes ❑ No Average # of bowel movements per day/week: ____/____

SYMPTOM	DATE OF ONSET	SYMPTOM	DATE OF ONSET	SYMPTOM	DATE OF ONSET
❑ Abdominal pain		❑ Change in bowel habits		❑ Incontinence of stool	
❑ Abnormal CT scan or ultrasound		❑ Chest pain		❑ Nausea and/ or vomiting	
❑ Abnormal liver enzymes		❑ Constipation		❑ Painful swallowing	
❑ Anemia		❑ Diarrhea		❑ Rectal bleeding	
❑ Black, tarry stools		❑ Difficulty Swallowing		❑ Vomiting blood	
❑ Bloating/Gas		❑ Excessive Belching		❑ Weight loss	
❑ Blood in a stool on test		❑ Heartburn / GERD		❑ Other	
		❑ Hepatitis / Jaundice			

PAST MEDICAL ILLNESSES Check if you have a history of any of the following. Please check all that apply.

❑ **NONE**

GASTROINTESTINAL

❑ Barrett's esophagus	❑ Colon polyps	❑ Fatty liver	❑ Pancreatitis
❑ Celiac disease	❑ Crohn's disease	❑ Hiatal hernia	❑ Stomach ulcer
❑ Cirrhosis	❑ Diverticulitis	❑ H. Pylori	❑ Ulcerative colitis
❑ Colon cancer	❑ Diverticulosis	❑ Irritable bowel (IBS)	❑ Other_____

CARDIOVASCULAR

❑ Atrial fibrillation	❑ Coronary artery diseases	❑ High blood pressure	❑ Other_____
❑ Chest pain	❑ Extra heart beats (PVC)	❑ Slow heart beat	
❑ Congestive heart failure	❑ Heart attack	❑ Supraventricular tachycardia	

PULMONARY

❑ Asthma ❑ Sleep apnea
❑ I use CPAP machine ❑ Other_____
❑ Emphysema (COPD)

ENDOCRINE

❑ Diabetes
❑ Insulin pump
❑ Other_____

NEUROPSYCHIATRIC

❑ Stroke
❑ TIA (mini-stroke)
❑ Other_____

GENITOURINARY

❑ Kidney disease
❑ Renal failure
❑ Other_____

HEMATOLOGIC

❑ Bleeding disorders ❑ Other_____
❑ Clotting disorders
❑ Low platelets

ONCOLOGY

Any malignant tumors not previously mentioned
_____

CONTINUED

DIAGNOSTIC TESTS Check the boxes below if you have had any of the following tests and indicate the date.

❑ **NONE**

	Date		Date
❑ Barium enema		❑ MRI (abdomen/pelvis)	
❑ Colonoscopy		❑ Ultrasound (abdomen)	
❑ CT scan (abdomen/pelvis)		❑ Upper Endoscopy (EGD)	
❑ Flexible sigmoidoscopy		❑ Upper GI Series	

PAST SURGICAL HISTORY Check the boxes below if you have had any of the following surgeries and indicate the year.

❑ **NONE**

	Year		Year		Year
❑ Appendix surgery		❑ Heart catherization		❑ Hysterectomy	
❑ Back/spine surgery		❑ Heart defibrillator		❑ Neck surgery	
❑ Bariatric surgery		❑ Heart pacemakeer		❑ Rectal surgery	
❑ Bresast surgery		❑ Heart stenting		❑ Other	
❑ Heart bypass		❑ Heart valve replacement			
❑ Gall bladder removal		❑ Hernia repair			

ALLERGIES List all allergies, including medication allergies (also include over-the-counter medications) Indicate reaction to allergy (ie. rash, hives, shock, etc.) and if hospitalized for treatment.

❑ **NONE**

Allergy	**Reaction**	
		Hospitalized ❑ Yes ❑ No
		Hospitalized ❑ Yes ❑ No

Check all statements which apply

❑ I have had prior difficulties with anesthesia
❑ I have a latex allergy
❑ I require antibiotics prior to surgery
❑ I have an allergy to Iodine or IV Contrast

MEDICATION LIST List medication names, doses and how often taken. Include “over-the-counter” medications.

❑ **NONE**

Medication Name	**Dose**	**Frequency taken (eg: once per day)**

If on a blood thinner, please check ❑ Coumadin ❑ Warfarin ❑ Plavix ❑ Pradaxa ❑ Other_____

FAMILY HISTORY ❑ **NONE**

	Relationship/Age Diagnosed		Relationship/Age Diagnosed		Relationship/Age Diagnosed
❑ Breast cancer		❑ Pancreatic cancer		❑ Esophageal cancer	
❑ Liver cancer		❑ Colon polyps		❑ Ulcerative colitis	
❑ Celiac disease		❑ Stomach cancer		❑ Kidney cancer	
❑ Ovarian cancer		❑ Crohn’s disease		❑ Uterine cancer	
❑ Colon cancer		❑ Thyroid cancer			

SIGNATURE

DATE

FINANCIAL POLICY

FOR PATIENTS WITH INSURANCE: Co-payments, coinsurance and/or deductibles are the responsibility of the patient or responsible party and due at the time of service. It is the patient's responsibility to obtain a written referral and authorization if their insurance carrier requires the same. Failure to obtain the referral and/or preauthorization may result in a lower or no payment from the insurance company.

FOR PATIENTS WITHOUT INSURANCE: I understand that payment for services rendered by DDA is due and payable in full at the time services are rendered, unless prior arrangements have been made with an employee of DDA.

IN THE EVENT: The Patient submits payment by check and that check is returned for any reason by the Bank, DDA will add $30.00 to the balance owed by the Patient or Responsible Party.

NO STATEMENT BY AN EMPLOYEE or agent of DDA will contradict, void, or nullify this agreement, nor shall the patient rely on any state-ments or opinions made by DDA that Patient's insurance carrier will pay the bill.

PAYMENTS: Unless other arrangements are approved by DDA in writing, the balance on your statement is due and payable when the statement is issued, and past due if payment is not received within 60 days after adjudication by your insurance carrier.

PAST DUE ACCOUNTS: If your account becomes past due, we will take the steps necessary to collect this debt. If we have to refer your account to a collection agency and/or an attorney, you agree to pay all of the collection costs that are incurred, including attorney fees and court costs, if applicable. Any balance unpaid after 60 days from the date services were rendered will be subject to interest at the annual percentage rate of 18% percent

WAIVER OF CONFIDENTIALITY: You understand if your account is submitted to an attorney and/or collection agency, if DDA has to litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you received treatment and that your account is delinquent with DDA will become a matter of public record.

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I give my consent for treatment and authorize the release of clinical information to other medical professionals who have need of such use for the provision of my care. **I hereby authorize DDA** to release all medical and billing information necessary to secure payment from any insurance carrier on my behalf. **Authorization is hereby given to DDA** to submit all claims directly to my insurance company on my behalf and authorize my insurance carrier to forward payment directly to DDA.

CONFIDENTIAL COMMUNICATION OF PERSONAL HEALTH INFORMATION

(Please provide information below on how we should contact you.)

I hereby authorize DDA to communicate ~~information regarding my evaluation, diagnosis, treatment and~~ billing to/with:

❑ My spouse/family member/other _____ _____
NAME INITIALS

❑ My spouse/family member/other _____ _____
NAME INITIALS

❑ If, when calling, we reach an answering machine or voicemail message, may we leave a message? ❑ Y ❑ N _____
INITIALS

AUTHORIZATION TO OBTAIN MEDICATION HISTORY

I authorize DDA to obtain my medication history from community pharmacies and/or Pharmacy Benefit Managers for the purpose of my treatment.

AUTHORIZATION AND ACKNOWLEDGMENT

By my signature affixed below, I acknowledge that I have read and agree to comply with the Financial Policy for Digestive Disease Associates as described above, that I give my authorization as described in the section titled Authorization for Release of Medical Records, that I have provided the information as requested in the section titled Confidential Communication of Personal Health Information, that I give authorization to DDA to obtain my Medication History as indicated above and that I have received a copy of the Digestive Disease Associates Notice of Privacy Practices.

_____ _____
SIGNATURE OF PATIENT OR RESPONSIBLE PARTY DATE

_____ _____
IF RESPONSIBLE PARTY, PLEASE PRINT NAME RELATIONSHIP TO PATIENT

APPOINTMENT CANCELLATION / NO-SHOW POLICY

Digestive Disease Associates is privileged to provide medical and endoscopic treatment for our patients. We work diligently to maintain a high level of professional and personalized service. We strive to accommodate our patient's needs for office visits and procedures in a timely manner. This requires careful planning and coordination amongst many individuals in our office. We understand that emergencies arise from time to time for our patients, just as they do for us. However, when a patient cancels an appointment or procedure without adequate notice, or simply fails to keep an appointment, we cannot use that time to serve the needs of other patients. Therefore, we have developed this policy regarding failure to keep appointments or canceled appointments without adequate notice. This policy will also apply to scheduled procedures, but the monetary consequences will be greater. We respectively request your understanding and agreement to our policy as is stated below.

OFFICE VISITS

Any established patient who fails to keep an appointment or who cancels or reschedules an appointment less than **24 HOURS** in advance of their appointment will be charged a fee of $50.00 per occurrence. For Monday appointments, cancellations must be made by noon on the preceding Friday. If an established patient fails to keep three appointments or fails to give adequate notice on three occasions, the practice will have the right to dismiss that patient.

PROCEDURES

Any patient who fails to keep an appointment for a procedure (upper endoscopy, colonoscopy, flexible sigmoidoscopy, endoscopic retrograde cholangiopancreatography) or remicade infusion; or who cancels or reschedules an appointment less than **48 HOURS** in advance of their procedure or infusion will be required to pay $100.00 per occurrence. For Monday appointments, cancellations must be made by noon on the preceding Thursday.

If an established patient fails to keep two appointments or fails to give adequate notice on two occasions, their primary care physician will be notified, and the practice will have the right to dismiss that patient from the practice.

FEES

All fees charged by Digestive Disease Associates pursuant to this No-Show / Cancellation Policy are not payable by your insurance company.

All fees are payable on or at your next office appointment with your Digestive Disease Associates physician or within 30 days of receipt of billing statement from Digestive Disease Associates for that fee, whichever is earlier.

Please remember that it is your responsibility to make certain that we have updated and/or accurate phone numbers and addresses so that we may contact you promptly.

Thank you for your consideration and understanding of our policy.

PATIENT SIGNATURE _____ DATE _____

DIGESTIVE DISEASE ASSOCIATES + GASTRO HEALTH

DRIVER RESPONSIBILITIES

As our patient, your safety is of utmost importance to us. You will be receiving intravenous sedation during your endoscopy procedure. Although the medications wear off gradually, you will still be under the effects of them when you leave the procedure. For example, your reflexes and your thinking may be slower than usual even though you will be awake when you are discharged. Because of this, we have strict guidelines for you to follow. **Failure to follow these guidelines will result in the rescheduling of your procedure, even if you have followed the preparation instructions.**

Read the following information and share it with your escort/driver prior to the date of your procedure:

1. You must have a responsible adult escort/driver, age 18 years or older, check in with you. This person must remain in the building throughout your procedure and recovery. Ask your escort/driver NOT to make appointments or plans for the time you are scheduled at the endoscopy center. DO NOT plan to phone your driver for pick up.

2. If you take Public transportation, such as a city bus, taxi, uber, etc. you must have a responsible escort/driver check in with you and remain in the building throughout your procedure.

3. Your escort/driver MUST check in with you and speak with the endoscopy center office staff when you arrive. If your escort/driver does not check in with you, your procedure will need to be rescheduled. If you have questions about this, contact our office at 410-247-7500.

4. The visit will take approximately two to three hours, from admission through discharge. The amount of time could be less or more, depending on unforeseen circumstances.

5. Your escort/driver must plan to drive you home immediately after discharge. The doctor may recommend that you eat sparingly, or not at all, in the hours immediately following the procedure. Please drink lots of fluid and eat soft, easily digestible foods which won't irritate your colon.

6. All patients receive written discharge instructions and information regarding their procedure. While your physician will talk with you briefly following your procedure, you may not remember specific conversation details due to the medications you received.

7. As authorized by you prior to your procedure, your physician may speak with your escort/driver regarding the findings of your exam and plan for your care while you are still in the recovery room.

PATIENT SIGNATURE _____ DATE _____

PRINTED NAME _____ DATE OF BIRTH _____